THE STATE OF NEW HAMPSHIRE

POINT OF SERVICE MEDICAL BENEFITS
PRESCRIPTION DRUG INSURANCE

Retirees Under Age 65 (excluding CA Residents)

EFFECTIVE DATE: October 1, 2003

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3309640

This document printed in July, 2004 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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Special Plan Provisions

Additional Programs

CG may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Employees for the purpose of promoting their general health and well being. Contact CG for details of these programs.

GM6000 PRM1

Notice of Federal Requirements

Coverage for Reconstructive Surgery Following Mastectomy

When a person insured for benefits under this certificate who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymphedema; and
- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

If you have any questions about your benefits under this plan, please call the number on your ID card or contact your employer.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

NOT101

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

If your Plan utilizes a network of Providers/Pharmacies, you will automatically, and without charge, receive a separate listing of Participating Providers/Pharmacies.

The Participating Provider/Pharmacy networks consist of a group of local practitioners and Hospitals of varied specialties as well as general practice; or a group of local Pharmacies, employed by or contracted with CIGNA HealthCare.

NOT88

Notice of Federal Requirements

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost-effective. This includes premiums for continuation coverage required by federal law.

NOT99

Notice Regarding Emergency Services and Urgent Care

In the event of an Emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a referral from your PCP for Emergency Services, but you need to call your PCP (if you have selected one) or the CIGNA HealthCare 24-hour Health Information Line as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP (if you have selected one) or the CIGNA HealthCare 24-hour Health Information Line will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call 24 hours a day, seven days a week to assist you when you need Emergency Services.

If you receive Emergency Services outside the service area, you must notify the Review Organization as soon as reasonably possible. The Review Organization may arrange to have you transferred to a Participating Provider for continuing or follow-up care, if it is determined to be medically safe to do so.

Urgent Care Inside the Service Area

For Urgent Care inside the service area, you must take all reasonable steps to contact your PCP (if you have selected one) or the CIGNA HealthCare 24-hour Health Information Line for direction and you must receive care from a Participating Provider, unless otherwise authorized by your PCP (if you have selected one) or the Review Organization.

Urgent Care Outside the Service Area

In the event you need Urgent Care while outside the service area, you should, whenever possible, contact your PCP (if you have selected one) or the CIGNA HealthCare 24-hour Health Information Line for direction and authorization prior to receiving services.

Continued or Follow-up Treatment

Continued or follow-up treatment, whether in or out of the service area is not covered unless it is provided or arranged for by your PCP (if you have selected one), a Participating Provider or upon prior authorization by the Review Organization.

GM6000 NOT91 V1

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY **THE STATE OF NEW HAMPSHIRE,** WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CONNECTICUT GENERAL DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CG," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

ASO1

Explanation of Terms

You will find terms starting with capital letters throughout this booklet. To help you understand your benefits, most of these terms are defined within the text or in the Definitions section.

THE SCHEDULE

The Schedule is a brief outline of the maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

How To File Your Claim

When you or your Dependents seek care through a Participating Provider, you are only responsible for the applicable Copayment amount shown in The Schedule. You do not need to file a claim form.

If you or your Dependents seek care through a non-Participating Provider, you must submit a claim form to be reimbursed.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to CG.

Doctor's Bills and Other Medical Expenses

The first medical claim should be filed as soon as you have incurred Covered Expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS

- BE SURE TO USE YOUR SOCIAL SECURITY AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

  YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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Eligibility - Effective Date

Eligibility for Retiree Insurance

You will become eligible for insurance if, on the day before you retire:

- you are an eligible, full-time or part-time employee; and
- you are in an Eligible Class for Retiree Insurance.

Eligibility for Dependent Insurance

You will become eligible for Dependent Insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Classes of Eligible Employees

Each retired employee under age 65, as reported by the Employer to CG

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ELI5 DG M

Retiree Insurance

This plan is offered to you as a Retiree. You will not be required to contribute toward the cost of the plan to be insured.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by signing an approved enrollment form, but no earlier than the date you become eligible. You must elect Retiree Insurance within 30 days after the date you become eligible.

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Dependent Insurance

You will not be required to contribute toward the cost of the plan to insure your Dependents.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved enrollment form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance for yourself, but not for your Dependents, will

become insured for Medical Insurance on the date of his birth, if you elect Dependent Medical Insurance no later than 31 days after his birth. If you do not elect Dependent Insurance within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Exception for Newborn Grandchildren

Any child born to your Dependent child while you are insured for Medical Insurance will be covered for the first 31 days of his life. Coverage for such child will not continue beyond the 31st day and no benefits for expenses incurred beyond the 31st day will be payable.

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Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93)

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

A. Eligibility for Coverage under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order.

You must notify your former Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the Qualified Medical Child Support Order being issued.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

(1) the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;

(2) the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;

(3) the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

(4) the order states the period to which it applies; and

(5) if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

OBRA1 M

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with States laws regarding child health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exceptions for Newborns" section of this certificate that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

OBRA2 M

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

When you elect Medical Insurance, you will have an opportunity to select a Primary Care Physician (PCP) for yourself and your Dependents from a list provided by CG. The Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Primary Care Physician's Role/Direct Access to Participating Physicians:

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

However, you and your Dependents are allowed direct access to Participating Physicians for covered services. Even if you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Physician of your choice, including Participating Specialist Physicians, for covered services.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

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Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this plan.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services;
- inpatient services at any participating Other Healthcare Facility;
- outpatient facility services;
- magnetic resonance imaging (MRI);
- non-emergency ambulance; or
- organ transplant services.

GM6000 PRA V2

Point of Service Medical Benefits

The Schedule

For You and Your Dependents

Point of Service Medical Benefits provide coverage for In-Network and Out-of-Network care. To receive Point of Service Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. For In-Network care, that portion is the Copayment. For Out-of-Network care, that portion is the Deductible or Coinsurance.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Out-of-Network portion of the plan.

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for the In-Network services rendered. Deductibles, applicable to Out-of-Network care, are also expenses to be paid by you or your Dependent. Deductible amounts are separate from, and not reduced by, Copayments. Copayments and Deductibles are in addtion to any Coinsurance.

If you are unable to locate an In-Network provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your benefit identification card to obtain authorization for Out-of-Network provider coverage. If you obtain authorization for services provided by an Out-of-Network provider, benefits for those services will be paid at the In-Network benefit level.

Self-Referral

Self-referral occurs when a person chooses to seek care or treatment from an In-Network provider without obtaining a referral from his Primary Care Physician. Benefits payable for Covered Expenses incurred for self-referred Physician or Inpatient Services will be determined by the In-Network provider in accordance with The Schedule below.

Guest Privileges

If you or one or your Dependents will be residing temporarily in another location where there is a network of Participating Providers, you may be eligible for Point of Service Medical Benefits at that location. However, the benefits available at the host location may differ from those described in this certificate. Refer to your Benefit Summary from the host location or contact your Employer for more information.

Benefits	This Plan will Pay:	
	In-Network	Out-of-Network
Lifetime Maximum Benefit	Unlimited	

Deductibles	You Pay: In-Network (with PCP Referral)	In-Network (Self-Referral)	Out-of-Network
Calendar Year Deductibles			
Deductibles are expenses to be paid by an Employee or Dependent for the services rendered Out-of-Network. These Deductibles are in addition to any Coinsurance.			
Individual Deductible	None	None	$150 per person
Family Deductible	None	None	$450 per family
After Out-of-Network Medical Deductible amounts totaling $450 have been applied in a calendar year for either: (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Out-of-Network Medical Deductible amounts for the rest of that calendar year.			

	In-Network (with PCP Referral)	In-Network (with Self-Referral)	Out-of-Network
Out-of-Pocket Expenses			
Out-of-Pocket Expenses are Covered Expenses incurred for charges made by: (a) Participating Providers (when self-referred); or (b) non-Participating Providers, for which no payment is provided because of the Coinsurance. However, any expenses incurred due to non-compliance penalties or charges in excess of Reasonable and Customary levels will not accumulate toward the Out-of-Pocket Maximums.			
Individual Out-of-Pocket Maximums	None	$600 per person	$900 per person
Family Out-of-Pocket Maximums	None	$1,800 per family	$2,700 per family
After Out-of-Pocket Expenses totaling to the amounts shown in the table above have been incurred in a calendar year for either: (a) you and your Dependents; or (b) your Dependents, your family need not satisfy any further Out-of-Pocket Expenses for the rest of that calendar year.			

Benefits	How This Plan Works:		
	In-Network (with PCP Referral)	**In-Network (with Self-Referral)**	**Out-of-Network**
For care other than for Mental Health and Substance Abuse	You or your Dependent pays the Copayments below, then the Plan pays the Benefit Percentage shown.	You or your Dependent pays the Copayment or Coinsurance below, then the Plan pays the Benefit Percentage shown.	You or your Dependent pays the Out-of-Network Deductible plus any Coinsurance below, then the Plan pays the Benefit Percentage shown.
Physician Services			
Physician Office Visit	$10 copay, then 100%	$30 copay, then 100%	80%, after plan deductible
Specialty Care Physician Office Visit	$10 copay, then 100%	$30 copay, then 100%	80%, after plan deductible
Surgery Performed in the Physician's Office	$10 copay, then 100%	$30 copay, then 100%	80%, after plan deductible
Allergy Treatment/ Injections	No Charge	No Charge	80%, after plan deductible
Allergy Serum (dispensed by the Physician in the office)	No Charge	No Charge	80%, after plan deductible
Preventive Care			
Well-Child Care (including vision and hearing screenings) through age 18	$10 per visit, then 100%	$30 per visit, then 100%	80% after plan deductible
Child Immunizations	No Charge	No Charge	No Charge

Annual Routine Physicals (including Well-Woman exams) for persons aged 19 and older	$10 per visit, then 100%	$30 per visit, then 100%	80% after plan deductible
Adult Immunizations	No Charge	No Charge	No Charge
Complete Vision Care Examination	$10 per examination, then 100%	$10 per examination, then 100%	80%, after plan deductible
Vision Benefit Maximum: For persons under age 19: 1 per calendar year For persons 19 or older: 1 every 2 calendar years			
Pap Test	No Charge*	No Charge*	80%, after plan deductible
Mammogram	No Charge*	No Charge*	No Charge
Prostate Specific Antigen (PSA)	No Charge*	No Charge*	80%, after plan deductible
	**Associated office visit subject to copay.*		
Pre-Admission Testing			
Primary Care Physician Office Visit	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Specialist Phsyician Office Visit	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Outpatient Facility	No charge for X-Ray/Lab if billed by a separate outpatient diagnostic facility	No charge for X-Ray/Lab if billed by a separate outpatient diagnostic facility	80% after plan deductible

Inpatient Hospital - Facility Services **Covered Expense Daily Limit**	No Charge	20% copay (Plan pays 80%)	80% after plan deductible
Semi Private Room and Board	The Hospital's negotiated rate	The Hospital's negotiated rate	The Hospital's most common daily rate for a semi-private room
Private Room	The Hospital's negotiated rate for a semi-private room	The Hospital's negotiated rate for a semi-private room	The Hospital's most common daily rate for a semi-private room
Special Care Units (ICU/CCU)	The Hospital's negotiated rate for an ICU/CCU room	The Hospital's negotiated rate for an ICU/CCU room	The Hospital's most common daily rate for an ICU/CCU room
Outpatient Surgical Facility Services Operating Room, Recovery Room, Procedure Room, and Treatment	No Charge	No Charge	80% after plan deductible

Second Opinions (Services will be provided on a voluntary basis)			
Primary Care Physician Office Visit	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Specialist Phsyician Office Visit	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Outpatient Facility	No Charge	No Charge	80% after plan deductible

Inpatient Hospital Doctor's Visits/Consultations	No Charge	20% copay (Plan pays 80%)	80% after plan deductible
Inpatient Hospital Professional Services: Surgeon Radiologist Pathologist Anesthesiologist	No Charge	20% copay (Plan pays 80%)	80% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	No Charge	No Charge	80% after plan deductible

Emergency and Urgent Care Services			
Physician's Office	$10 copay, then 100%	$10 copay, then 100%	$10 copay, then 100%
Hospital Emergency Room	$10 per visit, then 100% (waived if admitted) *	$10 per visit, then 100% (waived if admitted) *	$10 per visit, then 100% (waived if admitted) **
Urgent Care Facility or Outpatient Facility	$10 per visit, then 100% (waived if admitted) *	$10 per visit, then 100% (waived if admitted) *	$10 per visit, then 100% (waived if admitted) **
Ambulance	No Charge *	No Charge *	No Charge **

* *If not a true emergency, services are not covered.*

** *If not a true emergency, the Healthplan's approval is required to pay at the Plan's Out-of-Network coinsurance level.*

Inpatient Services at Other Health Care Facilities Includes: Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 100 Days	No Charge	20% (Plan pays 80%)	80% after plan deductible

Laboratory and Radiology Services			
MRIs, MRAs, CAT Scans and PET Scans	No Charge	No Charge	80% after plan deductible
Other Laboratory and Radiology Services (All charges billed by an independent facility)	No Charge	No Charge	80% after plan deductible

Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum In-Network: Unlimited Out-of-Network: $3,000 Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy	No Charge	No Charge	80% after plan deductible
Chiropractic Care Calendar Year Maximum: 12 Visits	$10 per visit, then 100%	$10 per visit, then 100%	80% after plan deductible

Home Health Care Calendar Year Maximum: Unlimited	No Charge	No Charge	80% after plan deductible

Hospice			
Inpatient	No Charge	No Charge	80% after plan deductible
Outpatient	No Charge	No Charge	80% after plan deductible

Bereavement Counseling	No Charge	No Charge	Not Covered

Maternity			
Initial Visit to Confirm Pregnancy	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
All Subsequent Prenatal Visits, Postnatal Visits, and Delivery	No Charge	No Charge	80% after plan deductible
Delivery (Inpatient Hospital, Birthing Center)	Same as Plan's Inpatient Hospital Facility benefit	Same as Plan's Inpatient Hospital Facility benefit	Same as Plan's Inpatient Hospital Facility benefit.

Abortion (Includes elective and non-elective procedures)			
Inpatient	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Surgical Facility	Same as plan's Outpatient Facility Services Benefit	Same as plan's Outpatient Facility Services Benefit	Same as plan's Outpatient Facility Services Benefit
Physician's Services	No Charge	No Charge	80% after plan deductible

Family Planning			
Office Visits including Tests and Counseling	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Surgical Sterilization Procedures for vasectomy/ Tubal Ligations (excluding reversals)			
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Facility	Same as plan's Outpatient Facility Services Benefit	Same as plan's Outpatient Facility Services Benefit	Same as plan's Outpatient Facility Services Benefit
Physician's Services	No Charge	No Charge	80% after plan deductible

Infertility Treatment			
Office Visit (Tests, Counseling)	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Surgical Treatment: Includes procedures for Correction of Infertility, In Vitro Fertilization, Artificial Insemination, GIFT, ZIFT, etc.			
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Same as plan's Inpatient Hospital Facility benefit	80% after plan deductible
Outpatient Facility	Same as plan's Outpatient Facility Services benefit	Same as plan's Outpatient Facility Services benefit	80% after plan deductible
Physician's Services	No Charge	No Charge	80% after plan deductible
Lifetime Maximum: Unlimited			

Organ Transplants Includes all medically appropriate non-experimental transplants			
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Same as plan's Inpatient Hospital Facility benefit	Same as plan's Inpatient Hospital Facility benefit
Physician's Services	No Charge	20% (Plan pays 80%)	80% after plan deductible
Travel Services Maximum (Covered only when transplant procedure is performed at a Lifesource Facility)	$10,000 per procedure	Not Covered	Not Covered

Durable Medical Equipment Calendar Year Maximum: Unlimited	No Charge	No Charge	80%, after combined $150 DME/EPA benefit deductible *(Plan deductible is waived.)*

External Prosthetic Appliances Calendar Year Maximum: Unlimited	No Charge	No Charge	80%, after combined $150 EPA/DME benefit deductible *(Plan deductible is waived.)*

Dental Care (Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth)			
Office Visits	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit	Same as plan's Outpatient Hospital Facility Benefit	Same as plan's Outpatient Hospital Facility Benefit
Physician's Services	No Charge	No Charge	80% after plan deductible

Temporomandibular Joint Disorder (Surgical & Non-Surgical Treatment)			
Office Visit	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit	Same as plan's Outpatient Hospital Facility Benefit	Same as plan's Outpatient Hospital Facility Benefit
Physician's Services	No Charge	No Charge	80% after plan deductible

	How This Plan Works:		
	In-Network (with PCP Referral)	**In-Network (with Self-Referral)**	**Out-of-Network**
For Mental Health and Substance Abuse Treatment	You or your Dependent pays the Copayments below, then the Plan pays the Benefit Percentage shown.	You or your Dependent pays the Copayment or Coinsurance below, then the Plan pays the Benefit Percentage shown.	You or your Dependent pays the Out-of-Network Deductible plus any Coinsurance below, then the Plan pays the Benefit Percentage shown.

Mental Health			
Inpatient	No Charge	20% (Plan pays 80%)	80% after plan deductible
Calendar Year Maximum: Unlimited			

Outpatient (Individual or Group Therapy) Calendar Year Maximum: Unlimited	$10 per visit, then 100%	$30 per visit, then 100%	80% after plan deductible

Substance Abuse			
Inpatient Calendar Year Maximum: The lesser of: (a) 30 Days; or (b) $3,000 *	No Charge	20% (Plan pays 80%)	80% after plan deductible
Outpatient (Individual or Group Therpay) Calendar Year Maximum: $3,000 * *** Combined Substance Abuse Maximums (Inpatient and Outpatient)** Per Calendar Year: $3,000 Lifetime: $10,000	$10 per visit, then 100%	$30 per visit, then 100%	80% after plan deductible

Point of Service Medical Benefits

For You and Your Dependents

The following PAC/CSR Requirements apply to Out-of-Network Hospital admissions only.

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital as a registered bed patient.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will not include the first $500 of Hospital charges made for each separate admission to the Hospital, unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission.

In addition, Covered Expenses incurred for which benefits would otherwise be payable under this plan will not include:

- Hospital charges for Bed and Board for any period of Hospital Confinement which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for which PAC was requested, but which were not certified as Medically Necessary.

GM6000 PAC1 V4 M

PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted.

GM6000 PAC2 V3

Benefit Payment

If, while insured for these benefits, you or any of your Dependents incur Covered Expenses, CG will pay an amount as determined in The Schedule.

Payment of any benefits will be subject to any applicable Copayments, Deductibles, and Benefit Maximums shown in The Schedule, and the Maximum Benefit Provision.

Full Payment Area (Out-of-Network)

When a person has satisfied the Individual Out-of-Pocket Maximum shown in The Schedule in any calendar year, benefits for that person for Covered Expenses incurred Out-of-Network during the rest of that calendar year will be payable at the rate of 100%.

When either: (a) you and your Dependents; or (b) your Dependents, have satisfied the Family Out-of-Pocket Maximum shown in The Schedule in any calendar year, benefits for you and all of your Dependents for Covered Expenses incurred Out-of-Network during the rest of that calendar year will become payable at the rate of 100%.

Refer to the "Out-of-Pocket Expenses" section in The Schedule for additional details.

All Copayments will continue to apply.

Maximum Benefit Provision

The total amount of Medical Benefits payable for all expenses incurred during a person's lifetime will not exceed the Maximum Benefit shown in The Schedule.

GM6000 CM3 FLX106V143 M

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CG. Any applicable Copayments, Deductibles or limits are shown in The Schedule.

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a Sub-Acute Facility for

medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.

- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.

GM6000 CM5 FLX107V101

- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration; therapy provided by a licensed physical, occupational or speech therapist.
- charges for the purchase, maintenance or repair of internal prosthetic medical appliances consisting of permanent or temporary internal aids and supports for defective body parts; specifically intraocular lenses, artificial heart valves, cardiac pacemakers, artificial joints, intrauterine devices and other surgical materials such as screw nails, sutures, and wire mesh; excluding all other prostheses.
- charges made for the initial purchase and fitting of external prosthetic devices which are used as replacements or substitutes for missing body parts and are necessary to alleviate or correct Sickness, Injury or congenital defect; including only artificial arms and legs and terminal devices such as hands or hooks. Replacement of such prostheses is covered only if needed due to normal anatomical growth.

GM6000 CM6 FLX108V636 M

- charges made for surgical and nonsurgical care of Temporamandibular Joint Dysfunction (TMJ), excluding appliances and orthodontic treatment.
- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for Family Planning, including: medical history; physical exam; related laboratory tests; medical supervision in accordance with generally-accepted medical practices; other medical services, information and counseling on contraception; implanted/injected contraceptives; and, after appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- charges made for Routine Preventive Care. Routine Preventive Care means health care assessments; well-child care; adult wellness visits; routine eye examinations; immunizations; annual well-woman examinations; and any related services.
- charges for the treatment of cancer by autologous bone marrow transplants, which follow the protocols reviewed and approved by the National Cancer Institute.
- charges for the cost of biologicals that are immunizations or medications for the purposed of travel.

GM6000 CM6 FLX108V620 M

- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for nutritional evaluation and counseling when diet is part of the medical management of a documented organic disease, including clinically-severe obesity.
- charges made for medical diagnostic services to determine the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Psychogenic erectile dysfunction does not warrant coverage for penile implants.

GM6000 INDEM62 INDEM62V5 M (1)

- charges made for a 48-hour inpatient stay following a vaginal delivery or a 96-hour inpatient stay following a caesarian section. An earlier discharge may be determined by the mother and attending Physician. An additional length of stay will be covered if deemed Medically Necessary.
- If discharge is prior to the 48/96 hours, at least 2 postpartum visits will be provided if the service is by a licensed Physician with experience in prenatal care.
- charges for Medically Necessary prenatal and/or postpartum homemaker services when a woman is confined to bed rest or her daily activities are restricted by her provider.
- charges incurred at birth for the delivery of a child only to the extent that they exceed the birth mother's coverage, if any, provided: (a) that child is legally adopted by you within one year from date of birth: (b) you are legally obligated to pay the cost of the birth; (c) you notify CG of the adoption within 60 days after approval of the adoption or a change in the insurance policies, plans or company: and (d) you choose to file a claim for such expenses subject to all other terms of these Medical Benefits.
- charges made by a Hospital or an Ambulatory Surgical Facility for anesthesia for inpatient Hospital dental procedures for: (a) a child under the age of 4; or (b) an

individual with a developmental disability or exceptional medical circumstances.

- charges made for treatment of Biologically-Based Mental Illness, as defined. Benefits for such Covered Expenses will be payable at the same rate as for other illnesses. Any Full Payment Area exceptions for mental illness will not apply to Biologically-Based Mental Illness.

GM6000 INDEM62 INDEM62V5 M (2)

- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes including, but not limited to: (a) one baseline low-dose mammogram for women ages 35 to 39 years of age; (b) a mammogram every one to years for women 40 to 49 years of age even if no symptoms are present ; and (c) one annual mammogram for women age 50 and over.
- charges for nonprescription eternal formulas and food products for the treatment of impaired absorption of nutrients caused by disorders of the gastrointestinal tract or inherited diseases of amino or organic acids. The Physician must issue a written order stating the eternal formula or food product is needed to sustain life, in the case of malabsorption; medically necessary; and the least restrictive and most cost effective means for meeting the needs of the insured. Coverage for inherited diseases of amino and organic acids will be subject to an annual maximum of $1,800.
- charges for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia including the treatment of breast cancer by autologous bone marrow transplants, or permanent loss of scalp hair due to injury, upon written recommendation of a Physician. Coverage for alopecia medicamentosa will be limited to $350 per year. Scalp hair prostheses means artificial substitues for scalp hair that are made for specific individual.
- charges for a drug that has been prescribed for specific indication for which use of the drug has not been approved by the U.S. Food and Drug Administration (U.S. FDA). Such drugs will be covered if: (a) the drug is recognized for treatment of the specific indication in one of the standard reference compedia or in medical literature as recommended by the American Medical Association: (b) it has not been contraindicated by the U.S. FDA for the use prescribed. Coverage will also be provided for any medical services necessary to administer the drug.

GM6000 INDEM62 INDEM62V5 M (3)

The following benefits will apply to insulin and noninsulin dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for Durable Medical Equipment, including podiatric appliances, related to diabetes. A special maximum will not apply.
- charges for insulin; syringes; prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips; urine test strips; lancets; and alcohol swabs.
- charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:

  (a) Medically Necessary visits when diabetes is diagnosed;

  (b) visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;

  (c) visits when reeducation or refresher training is prescribed by the Physician; and

  (d) Medical Nutrition therapy related to diabetes management.

GM6000 INDEM1 V14 M (2)

Home Health Services

- charges made for Home Health Care Services, when you:
- require skilled care;
- are unable to obtain the required care as an ambulatory outpatient; and
- do not require confinement in a Hospital or Other Health Care Facility.

Home Health Care Services are provided only if CG determines that the home is a medically-appropriate and cost-effective setting.

If you are a minor or an adult who is dependent upon others for nonskilled care (e.g. bathing, eating, toileting), Home Health Care Services will only be provided for you during times when there is a family member or care giver present in the home to meet your nonskilled care needs.

Home Health Care Services are those skilled health care services that can be provided during intermittent visits of two hours or less by Other Health Care Professionals. Necessary consumable medical supplies, home infusion therapy, and Durable Medical Equipment administered or used by Other Health Care Professionals in providing Home Health Care Services are covered. Home Health Care Services do not include services of a person who is a member of your family or your Dependent's family, or who normally resides in your home or your Dependent's home. Physical, occupational, and

speech therapy provided in the home are subject to the benefit limitations described under the section of this booklet entitled, "Short-Term Rehabilitative Therapy".

GM6000 INDEM2 V20

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
- by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Daily Limit shown in The Schedule;
- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;

GM6000 CM34 FLX124V26

    - physical, occupational and speech therapy;
    - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

  The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family, or who normally resides in your home or your Dependent's home;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living.

GM6000 CM35 FLX124V27

Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependents are Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization.

Partial Hospitalization sessions are periods of inpatient treatment provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

GM6000 INDEM9 V28 M

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital, in an individual, group or structured group therapy program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

GM6000 INDEM10 V18

Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions.

Partial Hospitalization sessions are periods of inpatient treatment provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, group, structured group or in a Substance Abuse Intensive Outpatient Structured Therapy Program.

A Substance Abuse **Outpatient Structured Therapy Program** consists of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive Outpatient Structured Therapy programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

GM6000 INDEM11 V17 M

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. CG will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Abuse Services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- Treatment of medical disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Residential treatment.
- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Other limitations are shown in the "General Limitations" section.

GM6000 INDEM12 V15

Durable Medical Equipment

- charges made the purchase or rental of Durable Medical Equipment which is ordered or prescribed by a provider and provided by a vendor approved by CG. Coverage for the repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to growth or a change in medical condition.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person, customarily serve a medical purpose, generally are not useful in the absence of Injury or Sickness, are appropriate for use in the home, and are not disposable. Such equipment includes, but is not limited to: crutches; Elastic (Jobst) Stockings; Hospital beds; wheel chairs; respirators; and dialysis machines.

Unless covered in connection with the services described in another section of this booklet, the following are specifically excluded:

- Hygienic or self-help items or equipment;
- Items or equipment that are primarily used for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
- Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
- Institutional equipment, such as air fluidized beds and diathermy machines;
- Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, orthotics, braces and splints;

- Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;

Items which under normal use would constitute a fixture to real property, such as ramps, railings, and grab bars.

GM6000 INDEM1 V14 M (1)

Infertility Services

- charges made for Infertility Services, including services related to the treatment of infertility once a condition of infertility has been diagnosed. Also, included are services for further diagnosis to determine the cause of infertility.

  Infertility Services include, but are not limited to: infertility drugs which are administered or provided by a Physician, surgeries and other therapeutic procedures, artificial insemination, laboratory tests, sperm washing or preparation, diagnostic evaluations, gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), and the services of an embryologist.

  This benefit includes diagnosis and treatment of both male and female infertility. However, the following are specifically excluded infertility services:

- a reversal of voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges and services,
- cryopreservation of donor sperm and eggs; and
- any experimental or investigational infertility procedures or therapies.

GM6000 INDEM5 V18 M

Short-Term Rehabilitative Therapy Services

- charges made for **Short-Term Rehabilitative Therapy** which is a part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically-appropriate inpatient or outpatient setting.

The following limitations apply to Short-Term Rehabilitative Therapy Services:

- Occupational therapy is provided only for purposes of training members to perform the activities of daily living.
- Speech therapy is not covered when (a) used to improve speech skills that have not fully developed; (b) considered custodial or educational; (c) intended to maintain speech communication; or (d) not restorative in nature.

Multiple services provided on the same day constitute one visit, but a separate Copayment will apply to the services provided by each Physician.

GM6000 INDEM8 V30

Chiropractic Care Services

- charges made for Chiropractic Care or services as follows:
- charges for care are limited to management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function;
- charges for office examinations, including: patient history; physical examination; spinal x-rays; laboratory tests; and neuromuscular treatment and manipulation.
- charges for lab work.

Charges are limited to care provided in an office setting, excluding any charges for:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- vitamin therapy;
- Maintenance Treatment or Preventive Treatment.

GM6000 INDEM8 V31 M

Organ Transplant Services

- charges made for human organ and tissue transplant services. All Organ Transplant Services listed below, other than cornea, kidney and autologous bone marrow/stem cell transplants, are available when received at qualified or provisional CIGNA Lifesource Organ Transplant Network facilities. The transplants that are covered at Participating Provider facilities other than a CIGNA Lifesource Organ Transplant Network facility are cornea, kidney and autologous bone marrow/stem cell transplants. All nonexperimental transplant procedures are covered at non-Participating Provider facilities (subject to approval by CG).

  Coverage is subject to the following conditions and limitations:

  Organ Transplant Services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ procurement. Organ Transplant Services are only covered when they are required to perform any of the following

human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or small bowel/liver.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

GM6000 INDEM3 V13 M

Organ Transplant Travel Services

CG will pay the travel expenses incurred by you or your covered Dependent for charges for transportation, lodging and food associated with a preapproved organ/tissue transplant. All expenses must be preapproved by your Transplant Case Manager. Organ Transplant Travel Benefits are not available for cornea, kidney and autologous bone marrow/stem cell transplants. Benefits for transportation, lodging and food are available to you only if you or your covered Dependent is the recipient of a preapproved organ/tissue transplant from a CIGNA Lifesource Organ Transplant Network Facility; such benefits are not subject to any individual or family deductible shown in The Schedule. The term recipient is defined to include you or your covered Dependent receiving preapproved transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) posttransplant care. Additionally, this benefit is not subject to the Lifetime Maximum Benefit shown in The Schedule.

Travel expenses for the person receiving the transplant will include charges for:

1. transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
2. lodging while at, or traveling to and from the transplant site; and
3. food while at, or traveling to and from the transplant site.

By way of example, but not of limitation, travel expenses will not include any charges for:

a. transplant travel benefit costs incurred due to travel within 60 miles of your home;

b. laundry bills;

c. telephone bills;

d. alcohol or tobacco products; and

e. transportation charges which exceed coach class rates.

These benefits are only available if you or your Dependent is the recipient of an organ transplant. No benefits are available if you or your Dependent is a donor.

The charges associated with the items 1., 2. and 3. above will also be considered covered travel expenses for one companion to accompany you. The term companion includes a spouse, family member, legal guardian of you or your Dependent, or any person not related to you, but actively involved as your caregiver.

GM6000 ORG1 V10
GM6000 ORG2

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct severe facial disfigurements or severe physical deformity (other than abnormalities of the jaw related to TMJ disorder provided that : (a) the surgery or therapy restores or improves function; or (b) reconstruction is required as a result of medically necessary noncosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part including, but not limited to: microtia, amastia, and Poland Syndrome. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by CG.

GM6000 INDEM63 V5

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for, expenses incurred:

- for eyeglasses, hearing aids or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.

- for or in connection with treatment of the teeth or periodontium, unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery; or (d) charges made by a Physician for any of the following surgical procedures:
- surgical removal of bone impacted teeth;
- for the surgical procedure (excluding charges for related preoperative or post operative care, including medical, lab and x-ray benefits);
- for intravenous sedation furnished by the operating dentist or oral surgeon;
- for anesthesia furnished by an anesthesiologist who is not the operating dentist or oral surgeon; and
- gingivectomy (limited to the excision of the soft tissue wall of the "pocket" up to four quadrants per lifetime).

  No benefits will be available for x-rays of teeth, local anesthesia services by the surgeon, surgical exposure, osseous and flap procedures in conjunction with gingivectomy and other services for periodontal disease.
- for or in connection with procedures to reverse sterilization.
- for which benefits are not payable according to the "General Limitations" section.

GM6000 CM66 FLX110V290 M

- for replacement of external prostheses due to wear and tear, loss, theft or destruction; or for any biomechanical external prosthetic devices.
- for treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
- unless otherwise covered as a basic benefit, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- for therapy to improve general physical condition if not Medically Necessary, including, but not limited to, routine, long-term chiropractic care, and rehabilitative services which are provided to reduce potential risk factors in patients in which significant therapeutic improvement is not expected.
- treatment by acupuncture.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, garter belts, corsets, hearing aids, dentures and wigs.

GM6000 INDEM7 V16 M

- for Cosmetic Surgery or Therapy. Cosmetic Surgery or Therapy is defined as surgery or therapy performed to improve appearance or self-esteem.
- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically-severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guidelines, is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically-based guidelines, to be safe and effective for treatment of the condition.
- for court ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed under the "Covered Expenses" section of this booklet.
- for nonmedical ancillary services, including but not limited to vocational rehabilitation, behavioral training, biofeedback neurofeedback, hypnosis, sleep therapy, employment counseling, back school, work hardening, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- for consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of "Covered Expenses".
- for private Hospital rooms and/or private duty nursing unless determined by CG to be Medically Necessary.

GM6000 INDEM64 V6

- for routine foot care, including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary.
- for membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- for amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Necessary to determine the existence of a gender-linked genetic disorder.

- for genetic testing and therapy including germ line and somatic unless determined Medically Necessary by CG for the purpose of making treatment decisions.
- for fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in CG's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- for blood administration for the purpose of general improvement in physical condition.
- for costs of biologicals that are immunizations or medications or to protect against occupational hazards and risks.
- for cosmetics, dietary supplements, health and beauty aids and nutritional formulae. However, nutritional formulae are covered when required for: (a) the treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or (b) enteral feeding for which the nutritional formulae under state or federal law can be dispensed only through a Physician's prescription , and are Medically Necessar*y* as the primary source of nutrition.

GM6000 INDEM65 V5 M

- for personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- for orthognathic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. However, Medically Necessary treatment of TMJ disorder is covered.
- for all noninjectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the "Covered Expenses" section of this certificate.

GM6000 INDEM70 V3

Prescription Drug Benefits

The Schedule

For You and Your Dependents

Pharmacy Benefits	How This Plan Works:	
	Participating Pharmacy You or your Dependent must pay a portion of the cost for Covered Prescription Drugs. That portion is described below	**Non-Participating Pharmacy** You or your Dependent must pay a portion of the cost for Covered Prescription Drugs. That portion is described below

Calendar Year Deductible

Deductible amounts are expenses to be paid in each calendar year by you or your Dependent for Covered Prescription Drugs purchased from a retail Pharmacy. The Deductible is in addition to any Coinsurance. The Prescription Drug Deductible does not apply to charges made for Covered Prescription Drugs purchased from a mail-order Participating Pharmacy.

Per Individual	$50

Annual Benefit Maximum

The total amount of Prescription Drug benefits payable for all expenses incurred at a Pharmacy in a calendar year will not exceed the Annual Benefit Maximum shown below.

Annual Maximum	$2,000 per person per calendar year

Retail Prescription Drugs Prescription Drug Maximum: (No more than a 31-day supply per Prescription Order)	20% per Prescription Order after deductible (Plan pays 80%)	20% per Prescription Order after deductible (Plan pays 80%)

Mail-Order Prescription Drugs Mail-Order Drug Maximum: (No more than a 90-day supply per Prescription Order)	$4 per Prescription Order, then Plan pays 100%	Not Covered

Prescription Drug Benefits

For You and Your Dependents

If you or any of your Dependents, while insured for Prescription Drug Benefits, incur expenses for charges made by a Pharmacy, coverage will be provided for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, up to the Anual maximum Benefit shown in The Schedule. Coverage also includes Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for a Prescription Drug as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by CG as if it had been filled by a Participating Pharmacy.

Limitations

Each Prescription Order shall be limited as follows:

- up to a consecutive 31-day supply at a retail Pharmacy;
- up to a consecutive 90-day supply at a mail-order Participating Pharmacy;
- up to a dosage and/or dispensing limit as determined by the P & T Committee.

Coverage for Prescription Drugs and Related supplies is limited to "generic" drugs, unless a generic alternative does not exist or substitution is not permitted by state law.

GM6000 PHARM38 V38 M

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. If your Physician wishes to request coverage for a Prescription Drug or Related Supply for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to CG to request a prior authorization for coverage of the Prescription Drug or Related Supply. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for that Prescription Drug or Related Supply. The length of the authorization will depend on the diagnosis and Prescription Drug or Related Supply. When your Physician advises you that coverage for the Prescription Drug or Related Supply has been approved, you should contact the Participating Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drug or Related Supply is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drug or Related Supply should be covered.

If you have questions about a prior authorization request, you should call Member Services at the toll-free number on the ID card.

GM6000 PHARM39 V41

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance as shown in the Schedule after you have satisfied your Prescription Drug Deductible, if applicable. In no event will any Copayment exceed the cost of the Prescription Drugs and Related Supply.

When a treatment regimen contains more than one type of Prescription Drug which are packaged together for your or your Dependent's convenience, a Copayment will apply to each type of Prescription Drug.

Please refer to the Schedule for any required Copayments, Coinsurance, Deductibles or Maximums if applicable.

GM6000 PHARM39 V37 M

Exclusions

No payment will be made for the following expenses:

- drugs or medications available over-the-counter that do not require a prescription by federal or state law, and any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee (such as antihistamines);
- any drugs that are labeled as experimental or investigational as described under General Limitations;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances (other than Related Supplies);
- Norplant and other implantable contraceptive products;

GM6000 PHARM41 V17 DG M

- dietary supplements;
- drugs used for cosmetic purposes, such as drugs used to reduce wrinkles, drugs to promote hair growth as well as

drugs used to control perspiration and fade cream products;

- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue.

Other limitations are shown in the "General Limitations" section.

GM6000 PHARM42 V16 M

Reimbursement/Filing a Claim

When you or your Dependents purchase Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay only the Coinsurance amount shown in The Schedule after the Prescription Drug Deductible has been satisfied. You do not need to file a claim form.

If you or your Dependents purchase Prescription Drugs or Related Supplies through a retail non-Participating Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see your mail-order drug introductory kit for details, or contact Member Services for assistance.

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.

GM6000 PHARM40 V9 M

General Limitations

Medical Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which would not have been made if the person had no insurance;
- Out-of-Network, to the extent that the charges upon which they are based are more than Reasonable and Customary;
- for or in connection with Custodial Services, education or training;
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;

GM6000 GEN18V22 DG M

- for charges made Out-of-Network by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: The maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 of the amount otherwise payable for all other surgical procedures;

GM6000 GEN246V32 M

- for charges made Out-of-Network by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for Out-of-Network charges made by a cosurgeon in excess of the surgeon's allowable charge plus 20 percent (for purposes of this limitation, "allowable charge" means the amount payable to the surgeon prior to any reductions due to Coinsurance or Deductible amounts);
- for charges made for or in connection with the purchase or replacement of contact lenses except as specifically provided under "Covered Expenses"; however, the purchase of the first pair of contact lenses that follows cataract surgery will be covered;
- for charges made for or in connection with eye exercises; and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;
- for charges for supplies, care, treatment or surgery which are not considered Medically Necessary, as determined by CG;
- for charges made for or in connection with tired, weak or strained feet for which treatment consists of routine footcare, including but not limited to, the removal of calluses and corns or the trimming of nails unless medically necessary;
- for or in connection with speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.

GM6000 GEN253V104 M

for Experimental, Investigational or Unproven Services which are medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies, or devices that are determined by CG, to be:

(a) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal; or

(b) the subject of review or approval by an Institutional Review Board for the proposed use; or

(c) the subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or

(d) not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- for expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or

Canadian resident and the charges are incurred while traveling on business or for pleasure.

- for nonmedical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.

GM6000 GEN321

- for medical treatment for a person age 65 or older who is covered under this plan as a retiree (or as a Dependent thereof), when payment is denied by Medicare because treatment was received from a non-participating provider;
- for medical treatment when payment is denied by a Primary Plan because treatment was received from a non-participating provider;
- for charges which you are not obligated to pay; or for which you are not billed; or for which you would not have been billed, except that they were covered under this plan.

GM6000 GEN325 M

- for Medical and Hospital care and costs for the infant child of a Dependent, unless that infant child is otherwise eligible under the Plan.

GM6000 GEN364V2 M

No payment will be made for expenses incurred for you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

- a "no-fault" insurance law; or
- an uninsured motorist insurance law.

CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.

GM6000 GEN151

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

(1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.

(2) Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.

(3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

GM6000 COB11 M

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

(1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.

(2) If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the

difference in cost between a private and semiprivate room is not an Allowable Expense.

(3) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

(4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

(5) If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of such a year during which you are not covered under this plan, or any date before this section or any similar provision takes effect.

GM6000 COB12 M

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

(1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;

(2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

(3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

(a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

(b) then, the Plan of the parent with custody of the child;

(c) then, the Plan of the spouse of the parent with custody of the child;

(d) then, the Plan of the parent not having custody of the child, and

(e) finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 COB13

(4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of this Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred percent (100%) of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. CG will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

GM6000 COB14

As each claim is submitted, CG will determine the following:

(1) CG's obligation to provide services and supplies under this policy;

(2) whether a benefit reserve has been recorded for you; and

(3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, CG will use the benefit reserve recorded for you to pay up to one hundred percent (100%) of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If CG pays charges for benefits that should have been paid by the Primary Plan, or if CG pays charges in excess of those for which we are obligated to provide under the Policy, CG will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CG will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

CG, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

GM6000 COB15

Right of Reimbursement

The Plan does not cover:

(1) Expenses for which another party may be responsible as a result of liability for causing, or contributing to, the Injury or Sickness of you or your Dependent(s).

(2) Expenses to the extent they are covered under the terms of any automobile medical, automobile no-fault, uninsured or underinsured motorist, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care expenses as described in (1) and (2) above, CG shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Plan. You or your Dependent(s), or a duly-appointed representative thereof, shall execute such documents as may be required to secure CG's rights. CG shall be reimbursed the lesser of:

the amount actually paid by CG [or the HealthPlan] under the Plan; or

an amount actually received from the third party,

at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or otherwise.

GM6000 CCP1 CCL1V4 M

Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical Benefits are not assignable unless agreed to by CG. CG may at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse; mother or father; child or

children; brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

CG, at its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology; and
- the methodologies as reported by generally-recognized professionals or publications.

GM6000 TRM366 M

Termination of Insurance

Termination of Insurance - Retirees

Your insurance will cease on the earliest date below:

- the date you cease to be in an Eligible Class or otherwise cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the plan is canceled.

Any continuation of insurance must be based on a plan which precludes individual selection.

GM6000 TER1 V-103
TRM23V3 DG M

Termination of Insurance - Dependents

Insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

Insurance for any one of your Dependents will cease on the last day of the calendar month in which that Dependent no longer qualifies as a Dependent.

GM6000 TRM62 M

Special Dependent Continuation of Medical Insurance

If you have been insured for at least 6 months and Medical Insurance for your Dependents would otherwise cease because of: (1) your death; (2) your entitlement to Medicare; (3) divorce or legal separation; or (4) with respect to a Dependent child, failure to continue to qualify as a Dependent, Medical Insurance may be continued upon payment of the required contribution to the Employer. It will continue until the earliest of:

For a spouse who is under age 55:

- 36 months from the date of (1), (2), (3) or (4) above, whichever may occur first;
- the last day for which the required contribution has been paid;
- the date the Dependent becomes entitled to Medicare;
- the date the Dependent becomes covered under another group health plan;
- the date the plan is cancelled.

For a spouse who is aged 55 or older:

- the date you or your former spouse remarries (at which time, coverage will continue as required under federal law);
- the date your former spouse becomes eligible for coverage under another group health plan;
- the date your former spouse becomes eligible for Medicare;
- the last day for which the required contribution has been paid;
- the date the plan is cancelled.

Notification and Election

The Employer should notify you of your right to continue insurance within 15 days after termination. You and your Dependents must submit an application and first contribution payment no later than 31 days after notice was sent.

GM6000 TRM111 V10 M

Special Continuation of Medical Insurance

If group medical coverage for you or your Dependents is cancelled for any reason, coverage may be continued from the date of cancellation until the earliest of the following:

- 39 weeks from the date group coverage is cancelled;
- the date the person fails to make any required payment in a timely fashion;
- the date the person becomes eligible for benefits under another group plan, or under Medicare; or
- the date your Dependent ceases to qualify as a Dependent under the provisions of the plan.

Notification and Election

You and your Dependents must submit an application and first required payment no later than 31 days after the date the group plan terminates. If CG does not notify you or your Dependents within 15 days after the date the group plan terminates, the application period will be extended to the earlier of: (a) 15 days after notice is received; or (b) 6 months from the date the person's original 31-day application period expired. If coverage for you and your Dependents ends because CG does not provide required notice of continuation, CG will be liable for any benefits payable during the lapse in coverage.

Interaction with Other Continuation

If coverage for your Dependents is being continued as provided under federal law and the group plan is cancelled before the continuation period expires, the person will be eligible for continued coverage as described above.

GM6000TER6 TRM109V2 M

Continuation Required by Federal Law For Your Dependents

Federal law enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation or, with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

COBRA13 M

Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

(1) your death;

(2) divorce or legal separation; or

(3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the Employer. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

COBRA14 M

If you retire within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If you retire more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date you retire.

COBRA4 M

Effect of Employer Chapter 11 Proceedings on Retiree Coverage

If you are covered as a Retiree, and a proceeding under USC Chapter 11, bankruptcy for the Employer results in a substantial loss of coverage for you or your Dependents within one year before or after such proceeding, coverage will continue until: (a) for you, your death; and (b) for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

COBRA15 M

Payment of Premium

This Plan may require the payment of an amount that does not exceed 102% of the applicable premium, except this Plan may

require payment of up to 150% of the Applicable Premium for any extended period of continuation coverage for a covered person who is disabled. The additional 48% may only be applied to the premium for the rating category that includes the disabled individual, and only for the additional 11 months.

Applicable Premium is determined as follows:

1. if the Retiree alone elects to continue coverage, the Retiree will be charged the active employee rate;

2. if a Dependent spouse alone elects to continue coverage, the spouse will be charged the active employee rate;

3. if a Dependent child or children elect to continue coverage without a parent also electing the continuation, each child will be charged the active employee rate;

4. if the entire family elects to continue coverage, they will be charged the family rate;

5. if the Schedule of Premium rates is set up on a step-rate basis, the active rate basis that fits the individuals who elect to continue their coverage is the rate that will be charged. If only children elect to continue coverage, each child will be charged the employee only rate.

Timely Payment

If payment is made within the grace period in an amount not significantly less than the amount the Plan requires to be paid, the amount must be deemed to satisfy the Plan's requirement. However, you must be notified and allowed at least 30 days after notice is provided for payment to be made.

Providing Notification of Your Status to Health Care Providers During the Grace Period

If, after you elect to continue coverage, a health care provider contacts this Plan to confirm coverage for a period for which premium has not yet been received, the Plan must give a complete and accurate response.

COBRA17 M

Notification Requirements

The Employer should send you initial notification of coverage continuation rights as required by federal law: (a) when the Plan first becomes subject to federal continuation requirements; or (b) when you add a spouse as a Dependent for benefits under the Plan. Receipt of this booklet may serve as such notice.

If you become eligible to continue coverage per federal law, the Employer must send you notification within 14 days. If the Plan has a Plan Administrator, the Employer must notify the Plan Administrator within 30 days. The Plan Administrator must notify you within 14 days, thereafter.

If eligibility to continue coverage is due to divorce, legal separation or a Dependent child losing eligibility for coverage under the Plan, you or your Dependent spouse must notify the Employer within 60 days of such event. The Employer must notify you of the right to continue coverage within 14 days after receipt of notification of such event.

COBRA18 M

Interaction With Other Continuation Benefits

A person who is so eligible to do so may continue the coverage, upon payment of any required contribution, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this booklet.

Newly-Acquired Dependents

If you acquire a new Dependent while benefits are being continued for your Dependents under the provisions of the continuation required by federal law, such Dependent will be eligible for coverage, provided:

- the required contribution is paid; and
- CG is notified of your newly-acquired Dependent in accordance with the terms of the plan.

If events (1) or (2) of under the section entitled, "Dependent Continuation Provision," should subsequently occur for your newly- acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

COBRA10 M

Medical Benefits Extension

Any expense incurred within 12 months after a person's Medical Benefits under this plan cease will be deemed to be incurred while he is covered if such expense is for an Injury or a Sickness which causes him to be Totally Disabled from the day his benefits cease until that expense is incurred.

The terms of this Medical Benefits Extension will not apply to: (a) a child born as a result of a pregnancy which exists when a person's Medical Benefits cease; or (b) any person, when he becomes covered under another group plan for Medical Benefits.

Totally Disabled

A person will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

GM6000 BEX182 V1 M

When You Have a Complaint or an Appeal

The following complies with federal law. Provisions of the laws of your state may supersede.

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the toll-free number on your Benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You can also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CG has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CG within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CG to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

GM6000 APL257

You may request that the appeal process be expedited if: (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or, in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

GM6000 APL258

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CG's level two appeal review denial. CG will then forward the file to the Independent Review organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by CG's Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CG.

GM6000 APL261

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgement for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level One and Level Two appeal processes. If your appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

GM6000 APL260

Arbitration

This provision does not apply to dental plans.

To the extent permitted by law, any controversy between CG and the Group, or an insured (including any legal representative acting on behalf of a Member), arising out of or in connection with this Certificate may be submitted to arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the

Commercial Arbitration Rules of the American Arbitration Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15 working day period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Certificate shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Certificate pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Certificate.

GM6000 ARB2

Definitions

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

DFS14

Biologically-Based Mental Illness

A Biologically-Based Mental Illness is defined as: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; and pervasive development disorder (autism).

DFS1570

Charges

The term "charges" means the actual billed charges, except when a provider has contracted, directly or indirectly, with CG for a different amount.

DFS940

Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

DFS1689

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including Mental Health and Substance Abuse). Custodial Services include, but shall not be limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

DFS1698

Dependent

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
- less than 19 years old;
- 19 years old or older, but less than 25 years old, enrolled in school as a full-time student and primarily supported by you. Proof of the child's age, status as a student and dependence must be submitted to CG as of the later of his 19th birthday or the date he is enrolled for Dependent Insurance. After that, CG may require such proof at least once each year until he attains age 25.
- 19 years old or older, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the

next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally-adopted child, including that child from the first day of placement in your home. However, if your petition of adoption is withdrawn or dismissed, coverage for the child will be terminated.

A child also includes a stepchild who lives with you, and any child for whom you are the legal guardian.

Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

DFS951 DG

Emergency Service/Emergency Medical Condition

Emergency Services are covered inpatient and outpatient services that are furnished by a qualified provider and are needed to evaluate or stabilize an Emergency Medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would result in one of the following:

(1) Placing the health of the individual, or with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;

(2) Serious impairment to bodily function; or

(3) Serious dysfunction of any bodily organ or part.

DFS1548

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CG is providing claim administration services.

DFS1595

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

DFS60

Formulary

Formulary means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Formulary have been approved in accordance with parameters established by the P&T Committee. The Formulary is regularly reviewed and updated.

DFS1709

Free-Standing Surgical Facility

The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

DFS682

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

DFS70

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

DFS599

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CG; and
- fulfills any licensing requirements of the state or locality in which it operates.

DFS72

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals; or
- an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; and (b) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

DFS1692

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a hospital upon the recommendation of a Physician; or
- Partially Confined for treatment for Mental Health or Substance Abuse in a Partial Hospitalization Program.

DFS1657

Injury

The term Injury means an accidental bodily injury.

DFS147

In-Network/Out-of-Network

The term In-Network refers to healthcare services or items provided by your Primary Care Physician or services/items provided by another Participating Provider and authorized by your Primary Care Physician or the Review Organization. Authorization by your Primary Care Physician or the Review Organization is not required in the case of Mental Health and Substance Abuse treatment, other than Hospital Confinement solely for detoxification.

The term Out-of-Network refers to care which does not qualify as In-Network.

Emergency Care which meets the definition of Emergency Services and is authorized as such by either the Primary Care Physician or the Review Organization is considered In-Network. (For details, refer to the Emergency Services and Urgent Care coverage section.)

DFS1694

Maintenance Treatment

The term Maintenance Treatment means treatment rendered to keep or maintain the patient's current status.

DFS1650

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

DFS192

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

DFS149

Medically Necessary/Medical Necessity

The term Medically Necessary/Medical Necessity means health care services and supplies that are determined by CG to be:

- required to meet your essential health needs;
- consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research;
- required for purposes other than the convenience of the provider or the comfort and convenience of the patient; and

- rendered in the least intensive setting that is appropriate for the delivery of health care.

DFS1684

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

DFS285

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

DFS155

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or a Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

DFS1686

Other Health Care Professional

The term Other Health Care Professional means an individual, other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Care Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

DFS1685

Participating Pharmacy

The term Participating Pharmacy means a retail Pharmacy with which CG has contracted to provide prescription services to insureds; or a designated mail-order Pharmacy with which CG has contracted to provide mail-order services to insureds.

DFS1712

Participating Provider

The term Participating Provider means an institution, facility, agency or health care professional which has contracted directly or indirectly with CG.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by the Employer.

DFS679

Pharmacy

The term Pharmacy means a retail pharmacy, or a designated mail-order pharmacy.

DFS1724

Pharmacy & Therapeutics (P & T) Committee

The Pharmacy & Therapeutics Committe is a committee comprised of Participating Providers, Pharmacists, medical directors and Pharmacy directors, which regularly reviews Prescription Drugs and Related Supplies for safety, efficacy, cost effectiveness and value. The P & T Committee evaluates Prescription Drugs and Related Supplies for addition to, or deletion from, the Formulary and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

DFS1707

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

DFS164

Prescription Drug

Prescription Drug means: (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; or (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

DFS1708

Prescription Order

The term Prescription Order means the lawful authorization of a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice; or each authorized refill thereof.

DFS1711

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

DFS1652

Primary Care Physician

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your insured Dependents.

DFS622

Provider Organization

The term Provider Organization refers to a network of Participating Providers.

DFS680

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include: (1) any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is: (a) operating within the scope of his license; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist; and (2) any psychotherapist while he is providing care authorized by the Provider Organization if he is: (a) state licensed or nationally certified by his professional discipline; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist.

DFS585

Reasonable and Customary

A charge will be considered Reasonable and Customary if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury, Sickness or condition being treated will be considered.

DFS527

Related Supplies

The term Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the Prescription Drug Benefit, and spacers for use with oral inhalers.

DFS1710

Retiree

The term Retiree means a fomer employee of the Employer whose active service ended due to retirement, as reported to CG.

DFS1427

Review Organization

The term Review Organization refers to an affiliate of CG or another entity to which CG has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

DFS1688

Sickness

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

DFS531

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DFS193

Specialist Physician

The term Specialist Physician means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine or pediatrics.

DFS1638

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

DFS197

DEF

THE STATE OF NEW HAMPSHIRE

COMPREHENSIVE MEDICAL BENEFITS

SPD for Retirees age 65 and Older

EFFECTIVE DATE: October 1, 2003

ASO12
3309640

This document printed in July, 2004 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Special Plan Provisions

Additional Programs

CG may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Employees for the purpose of promoting their general health and well being. Contact CG for details of these programs.

GM6000 PRM1

Notice of Federal Requirements

Coverage for Reconstructive Surgery Following Mastectomy

When a person insured for benefits under this certificate who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymphedema; and
- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

If you have any questions about your benefits under this plan, please call the number on your ID card or contact your employer.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

NOT101

Notice Regarding Pharmacy Directories and Pharmacy Networks

If your Plan utilizes a network of Pharmacies, you will automatically and without charge, receive a separate listing of Participating Pharmacies.

Your Participating Pharmacy network consists of a group of local Participating Pharmacies employed by or contracted with CIGNA HealthCare.

NOT87

Notice of Federal Requirements

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost-effective. This includes premiums for continuation coverage required by federal law.

NOT99

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY THE STATE OF NEW HAMPSHIRE WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CONNECTICUT GENERAL DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CG," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

ASO1

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

THE SCHEDULE

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

How to File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to CG.

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS

- BE SURE TO USE YOUR SOCIAL SECURITY AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

  YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

GM6000 CI 3 CLA9V31

Eligibility - Effective Date

Eligibility for Employee Insurance

You will become eligible for insurance on the date you retire if you are in a Class of Eligible Employees.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you first acquire a Dependent.

Classes of Eligible Employees

Each Retired Employee as reported to the insurance company by your Employer.

GM6000 EL 2 V-31
ELI5 M DG

Employee Insurance

This plan is offered to you as an Employee.

Effective Date of Your Insurance

You will become insured on the date you become eligible.

If you are not in Active Service on the date you would otherwise become insured, you will become insured on the date you return to Active Service.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance will become insured for Medical Insurance on the date of his birth, if you elect Dependent Medical Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Exception for Newborn Grandchildren

Any child born to your Dependent child while you are insured for Medical Insurance will be covered for the first 31 days of his life. Coverage for such child will not continue beyond the 31st day and no benefits for expenses incurred beyond the 31st day will be payable.

GM6000 EF 3 ELI38V5 M

Comprehensive Medical Benefits

The Schedule

For You and Your Dependent

Please refer to the section of The Schedule entitled "How Your Comprehensive Medical Plan Works" and to the Comprehensive Medical Benefits text in this certificate for a complete explanation of your benefits and any restrictions.

Benefits	This Plan will Pay:
Lifetime Maximum Benefit	Unlimited

	How this Plan Works:
For care other than for Mental Health and Substance Abuse	The plan pays the Benefit Percentage shown

Physician Services	
Physician Office Visit	No Charge
Specialty Care Physician Office Visit	No Charge
Surgery Performed in the Physician's Office	No Charge
Allergy Treatment/Injections	No Charge

Preventive Care	
Well-Child Care including Immunizations for children to age 3	No Charge
Annual Routine Physicals age 3 and above	No Charge
Immunizations for age 3 and above (excluding immunizations for Travel)	NOT COVERED
Immunizations for Travel	No Charge
Calendar Year Maximum: Unlimited	
Well Woman Exam	No Charge
Calendar Year Maximum: 1 per Calendar Year	

Pap Test	No Charge
Mammogram	No Charge
Prostate Specific Antigen (PSA)	No Charge

Outpatient Pre-Admission Testing	
Primary Care Physician Office Visit	No Charge
Specialty Care Physician Office Visit	No Charge
Outpatient Facility	No Charge

Inpatient Hospital - Facility Services	No Charge
Semi Private Room and Board	The Hospital's most common daily rate for a semi-private room
Private Room	The Hospital's most common daily rate for a semi-private room
Special Care Units (ICU/CCU)	The Hospital's most common daily rate for an ICU/CCU room

Outpatient Facility Services	No Charge
Operating Room, Recovery Room, Procedure Room, and Treatment	

Inpatient Hospital Doctor's Visits/Consultations	No Charge
Inpatient Hosptial Professional Services: Surgeon Radiologist Pathologist Anesthesiologist	No Charge
Multiple Surgical Reduction	Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	No Charge

Emergency and Urgent Care Services	
Physician's Office	No Charge
Hospital Emergency Room	No Charge
Urgent Care Facility or Outpatient Facility	No Charge
Ambulance	No Charge

Inpatient Services at Other Health Care Facilities Includes: Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 100 Days	No Charge

Laboratory and Radiology Services	
MRIs, MRAs, CAT Scans and PET Scans	No Charge
Other Laboratory and Radiology Services (All charges billed by an independent facility)	No Charge

Outpatient Short-Term Rehabilitative Therapy 60 days per calendar year for all therapies combined Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Chiropractic Therapy (includes Chiropractors)	No Charge

Home Health Care Calendar Year Maximum: Unlimited Visits	No Charge

Hospice	
Inpatient Services	No Charge
Outpatient Services	No Charge

Bereavement Counseling	No Charge

Organ Transplants	
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit.
Physician Services	No Charge
Travel Services Maximum: (Covered only when procedure is performed at a Lifesource Facility)	$10,000 per transplant, per Lifetime

Durable Medical Equipment Calendar Year Maximum: Unlimited	No Charge

External Prosthetic Appliances Calendar Year Maximum: Unlimited	No Charge

Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.	
Doctor's Office	No Charge
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit
Physician's Services	No Charge

Temporomandibular Joint Disorder (Surgical & Non-Surgical Treatment)	
Doctor's Office	No Charge
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit
Physician's Services	No Charge

All Other Covered Expenses	No Charge

Mental Health and Substance Abuse Benefits	**How this Plan Works:**
	The plan pays the Benefit Percentage shown

Mental Health	
Inpatient	Same as plan's Inpatient Hospital Facility Benefit
Calendar Year Maximum: Unlimited	
Outpatient	No Charge
Calendar Year Maximum: Unlimited	
Group Therapy	No Charge
Calendar Year Maximum: Subject to the plan's Outpatient Mental Health benefit maximum.	

Substance Abuse	
Inpatient	Same as plan's Inpatient Hospital Facility Benefit
Calendar Year Maximum: Unlimited	
Outpatient	No Charge
Calendar Year Maximum: Unlimited	

Group Therapy Calendar Year Maximum: Subject to the plan's Outpatient Substance Abuse benefit maximum	No Charge

Comprehensive Medical Benefits

For You and Your Dependent

Certification Requirements

Note: PAC/CSR Requirements apply only to Retirees or Dependents: (a) who are not eligible for Medicare; or (b) for whom Medicare is secondary payer to this plan.

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

as a registered bed patient;

for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;

for the treatment of Substance Abuse in a Substance Abuse Intensive Outpatient Therapy Program;

for Mental Health or Substance Abuse Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will not include the first $500 of Hospital charges made for each separate admission to the Hospital:

unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission.

GM6000 PAC1 V24 M

Pre-Admission Certification/Continued Stay Review for a Hospital Confinement (Continued)

PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted. In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

GM6000 PAC2 V5

Coinsurance Provisions/Maximums

If, while insured for these benefits, you or your Dependent incurs Covered Expenses, CG will pay an amount shown in The Schedule.

Payment of any benefits will be subject to: (a) any Maximum Benefits shown in The Schedule; and (b) the Maximum Benefit Provision.

Maximum Benefit Provision

The total amount of Comprehensive Medical Benefits payable for all expenses incurred during a person's lifetime will not exceed the Maximum Benefit shown in The Schedule.

GM6000 COM619V3 M

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below, if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CG. Any applicable limits are shown in The Schedule.

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limits shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf, for medical care and treatment.
- charges made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a Subacute Facility on its own behalf, for medical care and treatment; except that Covered Expenses will not include that portion which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.

GM6000 COM622 V4 M

- charges made for Emergency Services and Urgent Care.

- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration; prosthetic appliances; and dressings.
- charges made for surgical and nonsurgical care of Temporomandibular Joint Dysfunction (TMJ), excluding appliances and orthodontic treatment.
- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes not to exceed (a) one baseline low-dose mammogram for women ages 35 to 39 years of age; (b) a mammogram every one to two years for women 40 to 49 years of age, even if not symptoms are present; and (c) one annual mammogram for women age 50 and over.
- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges for 48 hours inpatient stay following vaginal delivery or 96 hours following a cesarian section. An earlier discharge may be determined by the mother and attending Physician. An additional length of stay will be coverd if deemed medically necessary.

  if discharged prior to the 48/96 hours, at least 2 postpartum visits will be provided if the service is by a licensed Physician with experience in perinatal care
- charges for Medically Necessary prenatal and/or postpartum homemaker services when a woman is confined to bed rest or her daily activities are restricted by her provider.
- charges made for the initial purchase and fitting of external prosthetic devices which are used as replacements or substitutes for missing body parts and are necessary for the alleviation or correction of Injury or Sickness, or congenital defect. External prosthetic appliances shall include artificial arms and legs and terminal devices such as hands or hooks. Replacement of external prosthetic appliances is covered only if necessitated by normal anatomical growth.
- charges made by a Physician for visits for routine preventive care of a Dependent child during the first two years of that Dependents child's life, including immunizations.
- charges made for counseling and medical services connected with surgical therapies (vasectomy and tubal ligation), excluding procedures to reverse sterilization.

GM6000 COM623 V4 M

- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for nutritional evaluation and counseling when diet is part of the medical management of a documented organic disease, including clinically severe obesity.
- charges made for medical diagnostic services to determine the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Psychogenic erectile dysfunction does not warrant coverage for penile implants.

GM6000 INDEM62 V6

- charges made for routine Preventive Care from age 3, excluding immunizations other than for travel. Routine preventive care means health care assessments, wellness visits and any related services.
- charges for the cost of biologicals that are immunizations or medications for the purpose of travel.
- charge for well woman care including breast and pelvic examination, contraceptive information and counseling, minor infection treatment, pap smear (including Thin Prep Pap Test) and rectal exam.
- charges for Family Planning services including medical history, physical examination, related laboratory tests, medical supervision in accordance with generally accepted medical practice, other medical services, information and counseling on contraception, implanted/injected contraceptives.
- charges made by a Hospital or an Ambulatory Surgical Facility for anesthesia for inpatient Hospital dental procedures for: (a) a child under the age of 4; or (b) with a developmental disability or exceptional medical circumstances.
- charges made for treatment of Biologically-Based Mental Illness. Such Covered Expenses will be payable the same as for other illnesses once you have met the Mental Illness Maximums shown in The Schedule. Any Full Payment Area exceptions for mental illness will not apply to Biologically-Based Mental Illness once you have met the Mental Illness Maximums shown in the Schedule.
- charges for nonprescription eternal formulas and food products for the treatment of impaired absorption of nutrients caused by disorders of the gastrointestinal tract or inherited diseases of amino or organic acids. The

Physician must issue a written order stating the eternal formula or food product is needed to sustain life, in the case of malabsorption; medically necessary; and the least restrictive and most cost effective means for meeting the needs of the insured. Coverage for inherited diseases of amino and organic acids will be subject to an annual maximum of $1,800.

- charges for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia including the treatment of breast cancer by autologous bone marrow transplants, or permanent loss of scalp hair due to injury, upon written recommendation of a Physician. Coverage for alopecia medicamentosa will be limited to $350 per year. Scalp hair prostheses means artificial substitues for scalp hair that are made for specific individual.
- charges for a drug that has been prescribed for specific indication for which use of the drug has not been approved by the U.S. Food and Drug Administration (U.S. FDA). Such drugs will be covered if: (a) the drug is recognized for treatment of the specific indication in one of the standard reference compedia or in medical literature as recommended by the American Medical Association: (b) it has not been contraindicated by the U.S. FDA for the use prescribed. Coverage will also be provided for any medical services necessary to administer the drug.

The following benefits will apply to insulin and noninsulin dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for Durable Medical Equipment, including podiatric appliances, related to diabetes. A special maximum will not apply.
- charges for insulin; syringes; prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips; urine test strips; lancets; and alcohol swabs.
- charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:

  (a) Medically Necessary visits when diabetes is diagnosed;

  (b) visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;

  (c) visits when reeducation or refresher training is prescribed by the Physician; and

  (d) Medical Nutrition therapy related to diabetes management.

GM6000 COM624 V4 M

Home Health Care Services

- charges made for Home Health Care Services when you:
  - require skilled care;
  - are unable to obtain the required care as an ambulatory outpatient; and
  - do not require confinement in a Hospital or Other Health Care Facility.

Home Health Care Services are provided under the terms of a Home Health Care plan for the person named in that plan.

If you are an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), Home Health Care Services will only be provided for you during times when there is a family member or care giver present in the home to meet your nonskilled care needs.

Home Health Care Services are those skilled health care services that can be provided during intermittent visits of two hours or less by Other Health Care Professionals. Necessary consumable medical supplies, home infusion therapy, and Durable Medical Equipment administered or used by Other Health Care Professionals in providing Home Health Care Services are covered. Home Health Care Services do not include services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house. Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "Short-term Rehabilitative Therapy".

GM6000 INDEM2 V16 M

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live due to Terminal Illness for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Limit shown in The Schedule;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family

counseling, including bereavement counseling within one year after the person's death;

- for pain relief treatment, including drugs, medicines and medical supplies;
- by an Other Health Care Facility for:
  - part-time or intermittent nursing care by or under the supervision of a Nurse;
  - part-time or intermittent services of an Other Health Care Professional;

GM6000 COM141 V6

- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living.

GM6000 COM143 V8

Mental Health and Substance Abuse Services

If you or your Dependent, while insured for these benefits, incurs expenses for charges made for Medically Necessary Mental Health and Substance Abuse Services, CG will pay that portion of the expense remaining after you or your Dependent has paid any required Deductible or Coinsurance shown in the Schedule.

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent are Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization, and Mental Health Residential Treatment Services.

Inpatient mental health benefits are exchangeable with **Partial Hospitalization** sessions when benefits are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The benefit exchange will be that two partial hospitalization sessions are equal to one day of inpatient care.

Mental Health Residential Treatment Services are services provided by a Hospital that is designated by CG for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute mental health conditions.

Mental Health Residential Treatment benefits are exchanged with Inpatient Mental Health benefits at a rate of two days of Mental Health Residential Treatment being equal to one day of Inpatient Mental Health Treatment.

GM6000 INDEM9 V20 M

Mental Health Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of mental health conditions; (b) provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a Residential Treatment Center.

A person is considered Confined in a Residential Treatment Center when she/he is a registered bed patient in a Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat mental health when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital, in an individual, group or structured group therapy program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interferes with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital

problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

GM6000 INDEM10 V12

Inpatient Substance Abuse Rehabilitation Services are services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Residential Treatment Services and Partial Hospitalization.

Inpatient Substance Abuse benefits are exchangeable with **Partial Hospitalization** sessions when benefits are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The benefit exchange will be two partial hospitalization sessions are equal to one day of inpatient care.

Substance Abuse Residential Treatment Services are services provided by a Hospital that is designated by CG for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

Substance Abuse Residential Treatment benefits are exchanged with Inpatient Substance Abuse benefits at a rate of two days of Substance Abuse Residential Treatment being equal to one day of Inpatient Substance Abuse Treatment.

Substance Abuse Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse conditions; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (C) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a Residential Treatment Center.

A person is considered **Confined in a Substance Abuse Residential Treatment Center** when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

A **Substance Abuse Intensive Outpatient Therapy Program** consists of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive Outpatient Structured Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

GM6000 INDEM11 V10

Substance Abuse Intensive Outpatient Therapy Program benefits are exchanged with Inpatient Substance Abuse benefits at a rate of three days of Substance Abuse Outpatient Intensive Therapy being equal to one day of Inpatient Substance Abuse Rehabilitation Services.

Outpatient Substance Abuse Rehabilitation Services are services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, group, structured group.

GM6000 INDEM11 V19

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs. CG will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Abuse Services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- Treatment of medical disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Other limitations are shown in the "General Limitations" section.

GM6000 INDEM12 V11

Durable Medical Equipment

- charges made for the purchase or rental of Durable Medical Equipment which is ordered or prescribed by a provider and provided by a vendor approved by CG. Coverage for the repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to growth or a change in medical condition.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person, customarily serve a medical purpose, generally are not useful in the absence of Injury or Sickness, are appropriate for use in the home, and are not disposable. Such equipment includes, but is not limited to: crutches, elastic (Jobst) stockings, hospital beds, wheel chairs, respirators, and dialysis machines.

Unless covered in connection with the services described in another section of this certificate, the following are specifically excluded:

- Hygienic or self-help items or equipment;
- Items or equipment that are primarily used for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
- Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
- Institutional equipment, such as air fluidized beds and diathermy machines;
- Wigs;
- Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, orthotics, braces and splints;
- Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;

Items which under normal use would constitute a fixture to real property, such as ramps, railings, and grab bars.

GM6000 INDEM1 V17 M

Short-Term Rehabilitative Therapy

- charges made for **Short-Term Rehabilitative Therapy** which is a part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate inpatient or outpatient setting.

The following limitations apply to Short-Term Rehabilitative Therapy Services:

- Occupational therapy is provided only for purposes of training members to perform the activities of daily living.

Speech therapy is not covered when (a) used to improve speech skills that have not fully developed; (b) considered custodial or educational; (c) intended to maintain speech communication; or (d) not restorative in nature.

GM6000 INDEM8 V20

Organ Transplant Services

- charges made for human organ and tissue transplant services. Coverage is subject to the following conditions and limitations:

  Organ Transplant Services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ procurement. Organ Transplant Services are only covered when they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or small bowel/liver.

  Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

GM6000 INDEM3 V11

Organ Transplant Travel Services

CG will pay the travel expenses incurred by you or your covered Dependent for charges for transportation, lodging and food associated with a preapproved organ/tissue transplant. All expenses must be preapproved by your Transplant Case Manager. Organ Transplant Travel Benefits are not available for cornea, kidney and autologous bone marrow/stem cell transplants. Benefits for transportation, lodging and food are available to you only if you or your covered Dependent is the recipient of a preapproved organ/tissue transplant from a CIGNA Lifesource Organ Transplant Network Facility. Such benefits are not subject to any individual or family deductible shown in The Schedule. The term recipient is defined to include you or your covered Dependent receiving preapproved transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d)

posttransplant care. Additionally, this benefit is not subject to the Lifetime Maximum Benefit shown in The Schedule.

Travel expenses for the person receiving the transplant will include charges for

1. transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
2. lodging while at, or traveling to and from the transplant site; and
3. food while at, or traveling to and from the transplant site.

By way of example, but not of limitation, travel expenses will not include any charges for:

a. transplant travel benefit costs incurred due to travel within 60 miles of your home;

b. laundry bills;

c. telephone bills;

d. alcohol or tobacco products; and

e. transportation charges which exceed coach class rates.

These benefits are only available if you or your Dependent is the recipient of an organ transplant. No benefits are available if you or your Dependent is a donor.

The charges associated with the items 1., 2. and 3. above will also be considered covered travel expenses for one companion to accompany you. The term companion includes a spouse, family member, legal guardian of you or your Dependent, or any person not related to you, but actively involved as your caregiver.

GM6000 ORG1 V8

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- Charges made for reconstructive surgery or therapy to repair or correct severe facial disfigurements or severe physical deformity (other than abnormalities of the jaw related to TMJ disorder provided that : (a) the surgery or therapy restores or improves function or decrease risk of functional impairment; or (b) reconstruction is required as a result of medically necessary noncosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part including, but not limited to: microtia, amastia, and Poland Syndrome. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by CG.

GM6000 INDEM63 V6

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for expenses incurred:

- for eyeglasses, hearing aids or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by the outpatient department of a Hospital in connection with surgery.
- for which benefits are not payable according to the "General Limitations" section.

GM6000 COM343 V185

- for replacement of external prostheses due to wear and tear, loss, theft or destruction; or for any biomechanical external prosthetic devices.
- for treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
- for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- for therapy to improve general physical condition if not Medically Necessary, including, but not limited to, routine, and rehabilitative services which are provided to

reduce potential risk factors in patients in which significant therapeutic improvement is not expected.

- for routine chiropractic care to improve general physical condition whether or not it is Medically Necessary.
- treatment by acupuncture.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, garter belts, corsets, hearing aids, dentures and wigs.

GM6000 INDEM7 V17 M

- for Cosmetic Surgery or Therapy. Cosmetic Surgery or Therapy is defined as surgery or therapy performed to improve appearance or self esteem.
- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
- for court ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed under the "Covered Expenses" section of this certificate.
- for Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs is also excluded from coverage.
- for nonmedical ancillary services, including but not limited to vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, work hardening, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- for consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of "Covered Expenses".
- for private Hospital rooms and/or private duty nursing unless determined by CG to be Medically Necessary.

GM6000 INDEM64 V7

- for routine foot care, including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary.
- for membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- for amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Necessary to determine the existence of a gender-linked genetic disorder.
- for genetic testing and therapy including germ line and somatic unless determined Medically Necessary by CG for the purpose of making treatment decisions.
- for fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in CG's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- for blood administration for the purpose of general improvement in physical condition.
- for costs of biologicals that are immunizations or medications to protect against occupational hazards and risks.
- for cosmetics, dietary supplements, health and beauty aids and nutritional formulae. However, nutritional formulae are covered when required for: (a) the treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or (b) enteral feeding for which the nutritional formulae under state or federal law can be dispensed only through a Physician's prescription and are Medically Necessary as the primary source of nutrition.

GM6000 INDEM65 V6 M

- for personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- for orthognathic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. However, Medically Necessary treatment TMJ disorder is covered.
- for all noninjectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the "Covered Expenses" section of this certificate.

GM6000 INDEM70 V4

Second Opinion Surgical Benefits

If, as a result of an Injury or a Sickness, you or your Dependent, while insured for these benefits and prior to the performance of an Elective Surgical Procedure recommended by a surgeon, asks for an opinion from another Physician who is qualified to diagnose and treat that Injury or Sickness, CG will pay the Covered Expenses incurred for the fee charged for that opinion. If a person incurs Covered Expenses for diagnostic laboratory or x-ray examinations asked for by the Physician who gives that opinion, CG will pay the Covered Expenses so incurred.

Payment will be made whether or not the Surgical Procedure is performed.

Payment will be subject to all terms of the policy except as otherwise provided in this section.

Limitations

No payment will be made for expenses incurred in connection with:

- cosmetic or dental Surgical Procedures not covered under the policy;
- minor Surgical Procedures that are routinely performed in a Physician's office, such as incision and drainage for abscess or excision of benign lesions;
- an opinion obtained more than 6 months after a surgeon has first recommended the Elective Surgical Procedure;
- an opinion rendered by the Physician who performs the Surgical Procedure.

Other Limitations are shown in the "General Limitations" Section.

No payment will be made under any other section for expenses incurred to the extent that benefits are payable for those expenses under this section.

Elective Surgical Procedure

The term Elective Surgical Procedure means a Surgical Procedure which is not considered emergency in nature and which may be avoided without undue risk to the individual.

Prescription Drug Benefits

The Schedule

For You and Your Dependent

Pharmacy Benefits	How this Plan Works:	
	Participating Pharmacy	**Non-Participating Pharmacy**
	You or your Dependent must pay a portion of Covered Prescription Drugs. That portion is described below	You or your Dependent must pay a portion of Covered Prescription Drugs. That portion is described below

Calendar Year Deductible Deductibles are expenses to be paid by you or your Dependent for Covered Prescription Drugs. These Deductibles are in addition to any coinsurance. The Prescription Drug Deductible does not apply to Covered Prescription Drugs purchased from a Participating Mail Order Pharmacy.	
Individual Deductible	$100

Out-of-Pocket Expenses Out-of-Pocket Expenses are Covered Expenses incurred for charges made by Participating and Non-Participating Providers for which no payment is provided because of the coinsurance factor and the deductible.	
Individual Out-of-Pocket Maximum	$180 per person per Calendar Year

Prescription Drugs Prescription Drug Maximum: 31 day supply per prescription order or refill.)	20% after deductible, per prescription order or refill	20% after deductible, per prescription order or refill

Mail-Order Drugs Mail-Order Drug Maximum: (No more than a 90-day supply per prescription order or refill.)	$4 per prescription order or refill, then 100%	Not Covered

* Designated as per generally-accepted industry sources and adopted by CG

Prescription Drug Benefits

For You and Your Dependent

Covered Expenses

If you or any one of your Dependent, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, coverage will be provided for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician. Coverage also includes Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependent by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for a Prescription Drug as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by CG, as if filled by a Participating Pharmacy.

Limitations

Each prescription order or refill shall be limited as follows:

- up to a consecutive 31-day supply, at a retail Pharmacy;
- up to a consecutive 90-day supply at a mail-order Participating Pharmacy;
- up to a dosage and/or dispensing limit as determined by the P & T Committee.

GM6000 PHARM38 V38 M

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. If your Physician believes or wishes to request coverage for a Prescription Drug or Related Supply for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to CG to request prior authorization for coverage of the Prescription Drug or Related Supply. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for that Prescription Drug or Related Supply. The length of the authorization will depend on the diagnosis and Prescription Drug or Related Supply. When your Physician advises you that coverage for the Prescription Drug or Related Supply has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drug or Related Supply is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drug or Related Supply should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

GM6000 PHARM39 V38 M

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance as shown in the Schedule after you have satisfied your Prescription Drug Deductible, if applicable. In no event will any Copayment exceed the cost of the Prescription Drugs and Related Supply.

When a treatment regimen contains more than one type of Prescription Drug which are packaged together for you or your Dependent's convenience, a Copayment will apply to each type of Prescription Drug.

Please refer to the Schedule for any required Copayments, Coinsurance, Deductibles or Maximums if applicable.

GM6000 PHARM39 V39

Exclusions

No payment will be made for the following expenses:

- drugs or medications available over-the-counter that do not require a prescription by federal or state law, and any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over-the-counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee (such as antihistamines);
- injectable drugs other than injectables, used to treat diabetes, acute migraine headaches, anaphylactic reactions, vitamin deficiencies and injectables used for anticoagulation after the first 60 days without prior authorization by CG;
- injectable infertility drugs;
- any drugs that are labeled as experimental or investigational as described under General Limitations;
- Food and Drug Administration (FDA) approved prescription drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies

published in a peer-reviewed national professional medical journal;

- Norplant and other implantable contraceptive products;
- any fertility drug;
- growth hormones after 60 days without prior authorization by CG;

GM6000 PHARM41 V15 M DG

- dietary supplements;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue.

Other limitations are shown in the "General Limitations" section.

GM6000 PHARM42 V16 M

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a Participating Pharmacy, you pay only the Deductible and Coinsurance amount shown in the Schedule. You do not need to file a claim form.

If you or your Dependents purchase your Prescription Drugs or Related Supplies through a non-Participating Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see your mail-order drug introductory kit for details, or contact Member Services for assistance.

See your Employers Benefit Plan Administrator to obtain the appropriate claim form.

GM6000 PHARM40 V9 M

General Limitations

Medical Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which would not have been made if the person had no insurance;
- to the extent that they are more than Reasonable and Customary Charges;
- for charges that are not Medically Necessary, except as specified in any certification requirement shown in The Schedule;
- for or in connection with Custodial Services, education or training;
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;

GM6000 GEN18V22 DG

- to the extent of the exclusions imposed by any certification requirement shown in The Schedule;
- for charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 of the amount otherwise payable for all other surgical procedures.

GM6000 GEN246V30 M

- for charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a cosurgeon in excess of the surgeon's allowable charge plus 20 percent; (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.);
- for charges made for or in connection with the purchase or replacement of contact lenses except as specifically provided under "Covered Expenses"; however, the purchase of the first pair of contact lenses that follows cataract surgery will be covered;
- for charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;
- for charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by CG;
- for charges made for or in connection with tired, weak or strained feet for which treatment consists of routine footcare, including but not limited to, the removal of calluses and corns or the trimming of nails unless medically necessary;
- for or in connection with speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.

GM6000 GEN253V104

No payment will be made for expenses incurred for you or any one of your Dependents:

- for Experimental, Investigational or Unproven Services which are medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies, or devices that are determined by CG, to be:
  (a) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal; or
  (b) the subject of review or approval by an Institutional Review Board for the proposed use; or
  (c) the subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or

(d) not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- for expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- for nonmedical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.

GM6000 GEN321

- for medical treatment for a person age 65 or older, who is covered under this policy as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a non-participating provider;
- for medical treatment when payment is denied by a Primary Plan because treatment was received from a non-participating provider;
- for charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this policy.

GM6000 GEN325

- for medical and Hospital care and costs for the infant child of a Dependent, unless that infant child is otherwise eligible under the certificate.

GM6000 GEN364V2

No payment will be made for expenses incurred for you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

- a "no-fault" insurance law; or
- an uninsured motorist insurance law.

CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.

GM6000 GEN151

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical or dental care or treatment:

(1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.

(2) Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.

(3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

GM6000 COB11

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

(1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.

(2) If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.

(3) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

(4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

(5) If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

GM6000 COB12

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

(1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;

(2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

(3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

(a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

(b) then, the Plan of the parent with custody of the child;

(c) then, the Plan of the spouse of the parent with custody of the child;

(d) then, the Plan of the parent not having custody of the child, and

(e) finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 COB13

(4) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Rules for Coordination with Medicare

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of this Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a

Claim Determination Period are not more than one hundred percent (100%) of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. CG will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

GM6000 COB14 M

As each claim is submitted, CG will determine the following:

(1) CG's obligation to provide services and supplies under this policy;

(2) whether a benefit reserve has been recorded for you; and

(3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, CG will use the benefit reserve recorded for you to pay up to one hundred percent (100%) of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If CG pays charges for benefits that should have been paid by the Primary Plan, or if CG pays charges in excess of those for which we are obligated to provide under the Policy, CG will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CG will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

CG, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

GM6000 COB15

Right of Reimbursement

The Policy does not cover:

(1) Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).

(2) Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance, other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care Expenses as described in (1) and (2) above, Connecticut General shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Policy. You or your Dependent(s) or their representative shall execute such documents as may be required to secure Connecticut General's rights. Connecticut General shall be reimbursed the lesser of:

the amount actually paid by CG (or the HealthPlan) under the Policy; or

an amount actually received from the third party;

at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

GM6000 CCP1 CCL1V4

Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical Benefits are not assignable unless agreed to by CG. CG may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or

children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

CG, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- The methodologies in the most recent edition of the Current Procedural terminology.
- The methodologies as reported by generally recognized professionals or publications.

GM6000 TRM366

Termination of Insurance

Termination of Insurance - Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.

Any continuation of insurance must be based on a plan which precludes individual selection.

GM6000 TRM15V44 M DG

Termination of Insurance - Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

GM6000 TRM62

Special Continuation of Medical Insurance - Dependents

If you have been employed or insured for at least 6 months and health insurance for your Dependents would otherwise cease because of: (1) your death; (2) your entitlement to Medicare; or (3) divorce or legal separation, Medical insurance may be continued upon payment of the required premium to the Employer. It will continue until the earliest of:

For a spouse who is age 65 or over:

- the date you or your former spouse remarries, upon which coverage will continue as required under federal law;
- the date your former spouse becomes eligible for coverage under another group health plan;
- the date your former spouse becomes eligible for Medicare;
- the last day for which the required premium has been paid;
- the date the policy is cancelled.

Notification and Election

Your Employer should notify you of your right to continue insurance within 15 days after termination. You and your Dependents must submit an application and first premium payment no later than 31 days after notice was sent.

GM6000 TRM111 V10 M

Special Continuation of Medical Insurance

If group medical coverage for you or your Dependents is cancelled for any reason, coverage may be continued from the date of cancellation until the earliest of the following:

- 39 weeks from the date group coverage is cancelled;
- the date the person fails to make a timely premium payment;
- the date the person becomes eligible for benefits under another group plan or under Medicare; or
- the date your Dependents ceases to qualify as a Dependent under the provisions of the plan.

Notification and Election

You and your Dependents must submit an application and first premium payment no later than 31 days after the date the

group plan terminates. If CG does not notify you or your Dependents within 15 days after the date the group plan terminates, the application period will be extended to the earlier of: (a) 15 days after notice is received; or (b) 6 months from the date the person's original 31-day application period expired. If coverage for you and your Dependents ends because CG does not provide required notice of continuation, CG will be liable for any benefits payable during the lapse in coverage.

Interaction with Other Continuation

If coverage for you or your Dependents is being continued as provided under federal law, and the group plan is cancelled before the continuation period expires, the person will be eligible for continued coverage as described above.

GM6000TER6 TRM109V2 M

Continuation Required by Federal Law For You and Your Dependents

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation,or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

A. Retirees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease for any reason other than gross misconduct prior to 18 months from the date you retire, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. You and your Dependent must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; (b) the date notice of the right to continue insurance is sent; or (c) the date the insurance would otherwise cease. You must pay the first premium within 45 days from the date you elect to continue coverage. Such insurance will not be continued by CG for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- the balance of 18 months from the date you retire;
- the date the policy cancels;
- upon cancellation of the retiree plan, the balance of 18 months from the date you retire if your former Employer provides coverage for active Employees;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- after you elect to continue this insurance, the date you first become entitled to Medicare, and for your Dependent, the date he first becomes entitled to Medicare;
- after you elect to continue this insurance, for you, the date you first become covered under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

COBRA13 M

B. Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

1) your death; or
2) divorce or legal separation; or
3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the former Employer. In the case of (2) above, you or your Dependent must notify your former Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of your retirement;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

COBRA14 M

C. Subsequent Events Affecting Dependent Coverage

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

If you or your Dependent who are not disabled elect to continue coverage, such family members of the disabled person may extend coverage for up to an additional 11 months, if they otherwise remain eligible, and notice of disability is provided as described in (b), below.

To be eligible you or your Dependent must:

(a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and

(b) notify the plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the Plan Administrator with a copy of the determination.

Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described in sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

COBRA4 M

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

If you or your Dependent who are not disabled elect to continue coverage, such family members of the disabled person may extend coverage for up to an additional 11 months, if they otherwise remain eligible, and notice of disability is provided as described in (b), below.

To be eligible you or your Dependent must:

(a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and

(b) notify the plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the Plan Administrator with a copy of the determination.

Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described in sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

COBRA4 M

D. Effect of Employer Chapter 11 Proceedings on Retiree Coverage

If you are covered as a retiree, and a proceeding under USC Chapter 11, bankruptcy for the Employer results in a substantial loss of coverage for you or your Dependent within one year before or after such proceeding, coverage will continue until: (a) for you, your death; and (b) for your Dependent surviving spouse, up to 36 months from your death.

COBRA15 M

E. Payment of Premium

This Plan may require the payment of an amount that does not exceed 102% of the applicable premium, except this Plan may require payment of up to 150% of the Applicable Premium for any extended period of continuation coverage for a covered person who is disabled. The additional 48% may only be applied to the premium for the rating category that includes the disabled individual, and only for the additional 11 months.

Applicable Premium is determined as follows:

1. if the retiree alone elects to continue coverage, the retiree will be charged the active Employee rate;

2. if a Dependent spouse alone elects to continue coverage, the spouse will be charged the active Employee rate;

3. if a Dependent child or children elect to continue coverage without a parent also electing the continuation, each child will be charged the Employee rate;

4. if the entire family elects to continue coverage, they will be charged the family rate;

5. if the Schedule of Premium rates is set up on a step-rate basis, the active rate basis that fits the individuals who elect to continue their coverage is the rate that will be charged. If only children elect to continue coverage, each child will be charged the Employee Only rate.

Timely Payment

If Payment is made within the grace period in an amount not significantly less than the amount the Plan requires to be paid, the amount must be deemed to satisfy the Plan's requirement. However, you must be notified and allowed at least 30 days after notice is provided for payment to be made.

F. Providing Notification of Your Status to Health Care Providers During the Grace Period

If, after you elect to continue coverage, a health care provider contacts this Plan to confirm coverage for a period for which premium has not yet been received, the Plan must give a complete and accurate response.

M

G. Notification Requirements

Your former Employer should send you initial notification of coverage continuation rights as required by federal law; (a) when the Plan first becomes subject to federal continuation requirements; (b) when you were hired; and (c) when you add a spouse as a Dependent for benefits under the Plan. Receipt of this certificate may serve as such notice.

If you become eligible to continue coverage per federal law, your former Employer must send you notification within 14 days. If the Plan has a Plan Administrator, the Employer must notify the Plan Administrator within 30 days. The Plan Administrator must notify you within 14 days, thereafter.

If eligibility to continue coverage is due to divorce, legal separation or a Dependent child losing eligibility for coverage under the Plan, you or your Dependent spouse must notify your former Employer within 60 days of such event. Your former Employer must notify you of the right to continue coverage within 14 days after receipt of notification of such event.

COBRA18 M

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

- the required premium is paid; and
- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events 1 or 2 of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

COBRA10

Benefits Extension

Medical Benefits Extension Upon Plan Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the plan, and you or your Dependent is Totally Disabled on that date due to Injury or Sickness, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

- The date you exceed the Maximum Benefit, if any, shown in the Schedule;
- The date you are covered for medical benefits under another group plan;
- The date you no longer Totally Disabled;
- 12 months from the date your Medical Benefits cease; or
- 12 months from the date the plan is canceled.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when you or your Dependent's Medical Benefits cease.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness you are unable to engage in the normal activities of a person of the same age, sex and ability.

Your Dependent will be considered Totally Disable if, because of an Injury or Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or

- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

GM6000 BEX182 V3 M

When You Have a Complaint or an Appeal

The following complies with federal law and is effective July 1, 2002. Provisions of the laws of your state may supersede.

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the toll-free number on your Benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You can also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CG has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CG within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CG to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

GM6000 APL257

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer,

in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

GM6000 APL258

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CG's level two appeal review denial. CG will then forward the file to the Independent Review organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by CG's Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CG.

GM6000 APL261

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgement for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level One and Level Two appeal processes. If your appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

GM6000 APL260

Arbitration

This provision does not apply to dental plans.

To the extent permitted by law, any controversy between CG and the Group, or an insured (including any legal representative acting on behalf of a Member), arising out of or in connection with this Certificate may be submitted to arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Arbitration Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after

the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15 working day period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Certificate shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Certificate pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Certificate.

GM6000 ARB2

Definitions

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

DFS14

Biologically-Based Mental Illness

A Biologically-Based Mental Illness is defined as: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; and pervasive development disorder (autism).

DFS1570

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including Mental Health and Substance Abuse). Custodial Services include, but shall not be limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

DFS1698

Dependents

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
  - less than 19 years old;
  - 19 years but less than 23 years old, enrolled in school as a full-time student and primarily supported by you;
  - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child, including that child from the first day of placement in your home. However, if your petition of adoption is withdrawn or dismissed, coverage for the child will be terminated.

A child also includes:

- a stepchild who lives with you;.
- a child related to you by blood or marriage if you are the child’s legal guardian and the child’s parents are deceased,

  provided that any such child is:
  - living with you in a parent-child relationship;
  - primarily dependent upon you for support; and
  - eligible to be reported on your or your spouses Federal Income Tax return.

Benefits for a Dependent child or student will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

DFS952 DG

Emergency Service/Emergency Medical Condition

Emergency Services are covered inpatient and outpatient services that are furnished by a qualified provider and are needed to evaluate or stabilize an Emergency Medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would result in one of the following:

(1) Placing the health of the individual, or with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;

(2) Serious impairment to bodily function; or

(3) Serious dysfunction of any bodily organ or part.

DFS1548

Employee

The term Employee means a retired employee.

DFS1427 M DG

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CG is providing claim administration services.

DFS1595

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

DFS60

Formulary

Formulary means a listing of approved drug products. The drugs and medications included have been approved in accordance with parameters established by the Provider Organization. This list is subject to periodic review and is amended as required.

DFS1499

Free-Standing Surgical Facility

The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

DFS682

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

DFS70

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

DFS599

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CG; and
- fulfills any licensing requirements of the state or locality in which it operates.

DFS72

Hospital

The term Hospital means:

- an institution operated pursuant to law or legally operated as a hospital which: (a) maintains, on the premises or in facilities available to the hospital on a prearranged basis, all facilities necessary for medical, diagnostic and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by or under the direction of Registered Graduate Nurses; and (d) maintains permanent medical history records;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare;
- an institution which: (a) specializes in treatment of mental illness, alcohol or drug abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency; or
- a Free-standing Surgical Facility.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

DFS81

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Substance Abuse in a Substance Abuse Intensive Therapy Program;
- receiving treatment in a Mental Health and Substance Abuse Residential Treatment Center.

DFS1775

Injury

The term Injury means an accidental bodily injury.

DFS147

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

DFS192

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

DFS149

Medically Necessary/Medical Necessity

The term Medically Necessary/Medical Necessity means health care services and supplies that are determined by CG to be:

- required to meet your essential health needs;
- consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research;
- required for purposes other than the convenience of the provider or the comfort and convenience of the patient; and
- rendered in the least intensive setting that is appropriate for the delivery of health care.

DFS1684

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

DFS151

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

DFS155

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or a Hospice Facility. Examples of Other

Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

DFS1686

Other Health Care Professional

The term Other Health Care Professional means an individual, other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Care Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

DFS1685

Participating Pharmacy

The term Participating Pharmacy means a retail pharmacy with which Connecticut General Life Insurance Company has contracted to provide prescription services to insureds; or a designated mail-order pharmacy with which CG has contracted to provide mail-order services to insureds.

DFS1712

Pharmacy

The term Pharmacy means a retail pharmacy, including both Participating Pharmacies and Non-Participating Pharmacies; or a designated mail-order pharmacy.

DFS1724

Pharmacy & Therapeutics (P & T) Committee

A committee of Provider Organization members comprised of Medical providers, Pharmacists, Medical Directors and Pharmacy Directors, which reviews medications for safety, efficacy, cost effectiveness and value. The P & T Committee evaluates medications for addition to or deletion from the Formulary and may also set dispensing limits on medications.

DFS1500

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

DFS164

Prescription Drug

Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; or (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

DFS1708

Prescription Order

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

DFS1711

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

DFS170

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

DFS527

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under this Prescription Drug Benefit, and spacers for use with oral inhalers.

DFS1710

Review Organization

The term Review Organization refers to an affiliate of CG or another entity to which CG has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

DFS1688

Sickness - For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

DFS531

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DFS193

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

DFS197

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